OMB#: 0935-0104

PATIENT ID: {HHRKUID}

AGENCY ID: {PDDIRID}

AGENCY NAME: {PROVNAME}

FORM ___ OF ___

{FORMNUM} {FORMTOT}

MEDICAL EXPENDITURE PANEL SURVEY
MEDICAL PROVIDER COMPONENT

HOME CARE EVENT BOOKLET
FOR NON-HEALTH CARE PROVIDERS

FOR

REFERENCE YEAR 1998

D1. During calendar year 1998, what was the (first/next) month during which your records show that services were provided in (PATIENT NAME)'s home?

MONTH: _____ YEAR: 1998

Month	**{EVNTBEGM}**
Year	**{EVNTBEGY}**

D2. I need to know which type or types of persons provided services at (PATIENT NAME)'s home during (MONTH) and either the number of hours or the number of visits for each type.

EXPLAIN IF NECESSARY: By type of person I mean a housekeeper, therapist, nurse aide, yard worker, and so forth.

Type of Person	**{HHTYPE#}**
Type of Person Description, Text	**{HHDES#}**
Type of Person - Hours	**{HHHOUR#}**
Type of Person - Minutes	**{HHMIN#}**
Type of Person - Visits	**{HHVIS#}**

OFFICE USE ONLY	TYPE OF PERSON	HOURS/MINUTES:		VISITS:	
|__|	_____	_____ / _____	OR	_____	|__|__| OFFICE USE ONLY
|__|	_____	_____ / _____	OR	_____	
|__|	_____	_____ / _____	OR	_____	
|__|	_____	_____ / _____	OR	_____	
|__|	_____	_____ / _____	OR	_____	
|__|	_____	_____ / _____	OR	_____	

D3. I need a description of the services provided during (MONTH).

Cleaning or Yard Work	**{CLEANING}**
Transportation	**{TRANSPRT}**
Shopping	**{SHOPPING}**
Emotional Support Person	**{ESUPPORT}**
Support Groups	**{SUPPTGRP}**
Child Care	**{CHILDCAR}**
Other	**{OTHRSERV}**
Other Specify, Text	**{OTSERVOS}**

	YES	NO
CLEANING OR YARD WORK	1	2
TRANSPORTATION	1	2
SHOPPING	1	2
EMOTIONAL SUPPORT PERSON OR ONE-ON-ONE BUDDY	1	2
SUPPORT GROUPS	1	2
CHILD CARE	1	2
OTHER (SPECIFY): _____	1	2

C2. What were the charges for the services provided to (PATIENT NAME) during (MONTH)?

TOTAL CHARGES: $_____.____

Total Charges **{TOTLCHRG}**

C3. NOT ASKED THIS VERSION

C4. Who paid your organization for the charges during (MONTH)?

ASK FOR EACH SOURCE OF PAYMENT MENTIONED: How much did (SOURCE OF PAYMENT) pay?

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

Patient or Family	**{PATPAYM}**
Medicare	**{CAREPAYM}**
Medicaid	**{AIDPAYM}**
Private Insurance	**{PINSPAYM}**
VA	**{VAPAYM}**
CHAMPVA/CHAMPUS	**{CHAMPAYM}**
Worker's Comp	**{WORKPAYM}**
Other	**{OTHRPAYM}**
Other Specify, Text	**{OTPAYMOS}**

a. Patient or patient's family $ _____.____

b. Medicare $ _____.____

c. Medicaid $ _____.____

d. Private Insurance $ _____.____

e. VA $ _____.____

f. CHAMPVA/CHAMPUS $ _____.____

g. Worker's Comp $ _____.____

h. OTHER (SPECIFY): _____ $ _____.____

C5. IF NOT VOLUNTEERED, ASK: And what was the total of all payments received for (MONTH)? [IF NOT AVAILABLE, COMPUTE.]

TOTAL PAYMENTS: $_____.____

Total Payments **{TOTLPAYM}**

BOX 1
DO TOTAL PAYMENTS (C5) EQUAL TOTAL CHARGES (C2)?
YES 1 (D4)
NO 2 (C6)

C6. It appears that the total payments were (less than/more than) total charges. What is the reason for that difference? [CODE 1 (YES) FOR ALL REASONS MENTIONED.]

Adjustment or discount	
Medicare	{DISCARE}
Medicaid	{DISCAID}
Contractual arrangement	{DISCNT}
Courtesy discount	{DISCRTS}
Insurance write-off	{DISINSU}
Worker's Comp	{DISWORK}
Other	{DISOTH}
Other Specify, Text	{DISOTOS}
Expecting additional payment	
Patient or Family	{EPAYPAT}
Medicare	{EPAYCAR}
Medicaid	{EPAYAID}
Private insurance	{EPAYPINS}
VA	{EPAYVA}
CHAMPVA/CHAMPUS	{EPAYCHAM}
Worker's Comp	{EPAYWORK}
Other	{EPAYOTH}
Other Specify, Text	{EPAYOTOS}
Charity care or sliding scale	{SLIDSCA}
Bad debt	{BADDEB}
Payment more than charges	
Medicare	{MORECARE}
Medicaid	{MORECAID}
Private Insurance	{MOREPINS}
Other	{PAYMOTH}
Other Specify, Text	{PAYMOTOS}

PAYMENTS LESS THAN CHARGES:	YES	NO
Adjustment or discount		
a. Medicare limit or adjustment	1	2
b. Medicaid limit or adjustment	1	2
c. Contractual arrangement with insurer or managed care organization	1	2
d. Courtesy discount	1	2
e. Insurance write-off	1	2
f. Worker's Comp limit or adjustment	1	2
g. Other (Specify:)_____	1	2
Expecting additional payment		
h. Patient or Patient's Family	1	2
i. Medicare	1	2
j. Medicaid	1	2
k. Private Insurance	1	2
l. VA	1	2
m. CHAMPVA/CHAMPUS	1	2
n. WORKER'S COMP	1	2
o. Other (Specify:)_____	1	2
p. **Charity care or sliding scale**	1	2
q. **Bad debt**	1	2
PAYMENTS MORE THAN CHARGES:		
r. Medicare Adjustment	1	2
s. Medicaid Adjustment	1	2
t. Private insurance adjustment	1	2
u. Other (Specify:)_____	1	2

D4. Have we covered all of the months your organization provided services to (PATIENT NAME) during the calendar year 1998?

Yes, all months covered,
No, need to cover additional months
{ALLEVNTS}

YES, ALL MONTHS COVERED..... .1 (D5)
NO, NEED TO COVER
ADDITIONAL MONTHS..... 2 (D1-NEXT EVENT FORM)

D5. REVIEW NUMBER OF MONTHS OF HOME CARE SERVICE REPORTED BY HOUSEHOLD. IF FEWER MONTHS OF SERVICE ARE REPORTED BY THE HOME CARE ORGANIZATION, PROBE TO EXPLAIN THE DIFFERENCE.

NO DIFFERENCE OR PROVIDER REPORTED MORE MONTHS OF HOME CARE SERVICE THAN HOUSEHOLD 1 (D6)

PROVIDER RECORDED FEWER VISITS:..... 2
PROBE: (PATIENT NAME) reported (NUMBER) months of home care service. Do you have any information in your records that would explain this discrepancy?

_____

_____

_____

D6. GO TO NEXT PATIENT FOR THIS PROVIDER.
IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.